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MORAL AND METAPHYSICAL REFLECTIONS ON MULTIPLE
PERSONALITY DISORDER

There is already much controversy over whether or not multiple personality disorder exists. Among the many concerns about this disease classification which I will not consider directly are the general objections to Freudian psychoanalysis and the specific objections to the entire so-called recovered memory movement. Frederick Crews, for example, has led a backlash against the latter by attacking the former as a pseudo-science, without a shred of evidence. Hence in his view, the recovered memory technique, used throughout the diagnosis and treatment of multiple personality disorder, is responsible for incredible tales, produced in an atmosphere of suggestion, and resulting in the ruin of many lives.¹

It follows from his and similar objections that patients, psychiatrists, writers, and others (Here we would have to include jurisprudential scholars) have been bamboozled into thinking that this phantasmagoric diagnosis is an authentic psychiatric entity. If there is no such diagnosis in reality, then the question of moral and legal responsibility for acts by those afflicted must turn on some other considerations than that of a delimited illness. The debate about moral and legal culpability would not be answered by this gambit of denying the disease. Instead other considerations would have to arise from the chaotic, out-of-control behaviors of the person, rather than from a specifically-described disorder with multiple causes and a natural history occurring in the absence of interventions.

My contribution to this discussion cannot add to or subtract from this debate. Instead, my reflections arise out of over 25 years of experience as a philosopher and ethicist accompanying physicians on attending rounds in academic health care centers. Among those I accompanied were psychiatrists, including the Chair of Psychiatry at our institution for 17 years. Prior to chairing the department, he had been the State Mental Health Commissioner, and was widely viewed as a professional to whom one could refer one's most difficult and challenging patients. Many of them suffered from various forms of personality disorders, and some from the diagnosis of MPD.



These patients are the source and stimulus of my thoughts, rather than theoretical disputes. Although I will make some suggestions, the patients and their physicians prompt me to raise more questions than answers.

All of these patients suffered immeasurably from a combination of genetic proclivities, family history, early and frequent psychological and sexual abuse, continued abusive relations into early adulthood, difficulties with work, family, and often the law, and more and more ferocious life experiences, leading to repeated suicide or self-mutilation attempts. Their dreams terrified them. Their waking hours terrified them. Who is to say which was worse? In successful instances, too, years of constant therapy, drug regimens, and hypnosis gradually reduced the symptoms and led to integration of the whole person.

First I will present my thesis. After case examples of the complexity of the problem, I will try to sketch a contrasting normal pattern of personal growth in which we hold persons responsible in some measure for their acts. "Normalcy" considerations also lead to examination of concepts of health related to social values. I will then consider objections to MPD as a diagnosis, and thus, objections to my argument, returning to the mutual responsibility thesis in light of that discussion as a penultimate consideration.

THESIS

Persons with MPD cannot bear standard degrees of moral and legal responsibility until the integrative stages of their recovery. Even then, due to the interweaving of the psychiatrist's and the patient's value systems and lives, it would make more sense during this recovery period to hold both individuals jointly but minimally responsible. This "mutual responsibility thesis" will be amplified and acquire nuances through case examples and reflections on normalcy. Near the end of this essay, I will return to the thesis and delineate some conditions under which personal accountability could arise.

CASE EXAMPLES

How can a woman's voice box yield two different male voices, one malevolent and the other a kinder, tenor role? Or how can a mouse of a young woman, confined to a motorized scooter because of diagnosed degenerative osteoarthritis, leap up and hurl grown men residents and doctors (and a not insubstantial ethicist) around a room? Or how can a

benign middle-aged woman who is writing right-handed in her journal suddenly, instantaneously become a left-handed male writer writing on the same page?

The answer to these case-based questions is that there is much more to the human spirit than we can fathom in our current theories. Thus, we develop a disease category for such individuals called MPD. We could just as well have considered these persons as immortal geniuses, or community prophetic leaders (as in the instance of a Ugandan I discuss later), or as the 19th Century did for physically abnormal people, circus freaks.

My own view is that the instinct for self-preservation is so immense, and so materially creative, that the threatened and vulnerable individual will ironically “split” into other or a multiplicity of others in order to survive. This process has a normal range between the instinctive thought that “I can’t believe I am in this situation,” to primordial rage and flight. Some individuals, perhaps those with genetic pre-disposition, will cope by creating other emotional structures that are survival tools so valuable that they are periodically nurtured and developed. They each grow at their own pace, and may split themselves later. The individual becomes like the plant in the movie, “The Little Shop of Horrors.” As it germinates and then grows out of control, its needs become more and more demanding. In such survivor clubs, we call these emotional constructs, “personalities” precisely because they are so well-developed and individualized.

One individual was a short master electrician with a deep bass voice. His odyssey is typical but remarkable for its tragedy. I cannot do justice to him here, but can only highlight the major movements in his care over the 17 years I knew him. The first hospitalization was due to rampant drinking and barroom brawls. The man had tremendous courage. He was decorated in the Navy during the Second World War, and saved two co-worker’s lives in his career as a master electrician. He was thrice able to stare down street robbers and dare them to kill him rather than turn over his money.

Thereafter, he revealed that he had been a cross-dresser all of his married life, and that each month he could feel himself move from his normal personality to something more feminine. This was treated somewhat experimentally with hormone therapy. Later he revealed through therapy that, although he and his wife had two grown sons (who never knew his intimate story), they had stopped making love long ago. She was an understanding woman. He described severe dissociation when making love, as if she had the penis and was penetrating him. This was so uncomfortable for him, that sexual desire vanished forever from his life.

Thereafter, through extensive hypnosis, recovered memory, and drug therapy, he recalled an early memory as an orphan and seeing a burn victim

in a hospital, holding the hand of a man. He could only now assume that was his mother and father, as he had never known anything about either of them. He was an orphan, he was told, and after a brief period of care with someone he knew as an aunt, he grew up in an orphanage. Still later, his memory recall therapy linked a current antipathy with an early memory. The early memory was of smelling a man's crotch, remembering a black car in a forest glen, and a man he thought was a funeral director. But his current antipathy was an active hatred of priests and ministers. If he saw one shopping or walking down the street, he would move to the other side. Memory recovery led to the identification of the man as the head of the orphanage, the smell as associated with sexual abuse, and the later hatred was tied to these early recalls. The patient then recalled going to confession and complaining that he did not want to play soccer like all the other kids. The priest, presumably a different one, just gave him a lot of manly advice. Still later he recalled that he was raised early on by an "aunt" who dressed him in girl's clothes.

During this time, after at least 12 years of therapy and hospitalizations, he began to see that he was an alcoholic. He entered AA and began to recover from his addiction. This program contributed to greater and greater self-understanding. Only about 15 years into therapy did it emerge that he had MPD, and that the dissociations, brawls, cross-dressing, and other features of his life were actually other personalities that he could now integrate. The last two years of his life were relatively peaceful. He was exceptionally fond of helping educate medical students, and was always courteous and cooperative with the staff and his therapist.

His greatest moral problem throughout his life was whether or not to tell his children that he had these problems. His therapist was concerned that there may have been a genetic proclivity for many of the problems he encountered, and that his sons might have profited from full disclosure, so that they could watch for signs in themselves or in their children. He demurred, and was not pressed. He died peacefully in his sleep last year.

The second case presented a dramatic opposite. A very low-affect young woman was treated for many years for "schizophrenia," until she became a serious problem for a referring psychiatrist. Through years of drug therapy, memory recall, and psychotherapy, her story was that she had MPD. One personality was a deeply religious young woman who planned to marry and adopt, another was a vamp who had multiple sexual encounters at work as a secretary, another was a young girl, and the most frightening part, another was "the beast." There were other various and sundry players. One was a powerful authority figure named Stephen. The young girl was a protectress named "Stephanie." But "the beast" was

incredible. He resided in the patient's womb. He clambered to get out. Despite efforts to convince her he was not very powerful if he could not get out of her womb on his own, the therapist, residents, staff, and I took "the beast" very seriously. The patient had had multiple suicide and self-mutilation attempts, all of which were aimed at her abdomen.

The triggering moral dilemma was the patient's request, in her middle thirties, to have a hysterectomy, arguing cogently that she could then rid herself of "the beast" once and for all. This was during the time she was beginning to integrate. The therapist, consultants, specialties, surgeons, and nurses all had differing perspectives on this request. Some were in favor of it, pointing out that the patient had well-considered views on the surgery. Others thought that the physicians considering this move were contemplating a mutilation of a young woman, violating fundamental principles of bodily integrity and portraying, by even contemplating such a procedure, a disregard for her limited autonomy and an anti-feminist medical bias.

It helps to know that by this time, the patient had recalled numerous times her being sexually abused by a Satanic Cult that met near her beautiful home in the Western Suburbs. Both of her parents were alcoholics who abused her as well. The baby-sitter took her to the cult meetings when she was only about four years old. She recalled under hypnosis and truth serum drugs that she had had a knife put in her hand and her hand was guided to plunge it into a sacrificial baby on an altar. She thought herself a killer. She also remembered having a snake put up her vagina by various authorities present at the cult meeting – a policeman, a lawyer, and so on. The high priest was named Stephen.

Later in her life, she joined the Church because a priest, also named Stephen, helped her immensely. She had contemplated entering a religious order and devoting her life to caring for the poor. Through spiritual direction, this priest helped in her diagnosis and got her the initial professional help.

Each time "the beast" emerged, this troubled young woman became a raging bull, powerfully overturning tables, picking up a chair with a 225 pound, athletic resident in it, and throwing it and him against a door. The voice was from another world. I used to ask how a woman's larynx could actually make such sounds. After one stormy session, the chief resident asked me privately if I believed in Satan, because he had just been converted to the view that this beast was not to be slighted! He was profoundly, existentially shaken. A number of exorcisms were attempted. The surgeon, upon meeting the patient, and assessing with us the morality of acceding to her request for a hysterectomy, was fearful, among other

things, that the beast would emerge even under general anaesthesia and destroy people present. Even though he eventually had too many objections to the surgery, his initial requirements were at least to have an exorcist and the therapist present during the surgery.

This case, not at all pleasant and comforting, led the therapist to seek counsel from authorities around the country who were more familiar with Satanic Abuse and its effects on individuals. In the end the surgery was not performed, and the case continued with difficulty. The girl could no longer work, and had moved back in with her parents.

These two cases are but a few I was privileged to be part of over the years. The overbearing presence of evil in the lives of these individuals led me to admire their incredible efforts to set straight their lives against odds that would most likely overwhelm the rest of us. In the conclusion I will reflect on MPD and the presence of evil. At this point, however, I would only note that the cases just presented underline the difficulty of holding such persons morally responsible and criminally liable. They are truly wrestling with demons. By association, the therapists who take on these individuals also should bear only minimal responsibility for their acts. Could it also be that many convicted prisoners have also dissociated so greatly during their criminal acts that they truly believe in their innocence despite the evidence that convicted them? If the answer is affirmative, then these individuals also bear diminished moral and legal liability.

Let us turn now to the opposite of the MPD cases and analyze normalcy and how it leads to our holding persons responsible for their behavior. Reflections on Normalcy

In terms of responsibility, the fundamental difference between a "normal" person and one with personality disorders, is that the normal person acts from an integrated centrality of personhood. This is an assumption we always make, but it bears some deeper analysis.

Integrity of the Person

By the integrity of the person I mean the right ordering of the parts to the whole, the balance and harmony between the various dimensions of human existence necessary for the well functioning of the whole human organism. The integrity of a person is expressed in a balanced relationship between the bodily, psycho-social, and intellectual elements of his or her life. No one element is out of proportion to the others. Each takes the lead when the good of the whole requires it. Each yields to the other in the interest of the whole. Integrity in this dynamic sense is synonymous with health. Disease amounts to dis-integration, a rupture of the unity of the person.² This rupture may occur in one or more of three spheres, each with its

own ethical implications: the corporeal, the psychological, and the axiological.

Bodily integrity implies a well-functioning organism physiologically, a body which can serve the aims and purposes of the person efficiently and effectively with a minimum of discomfort or disability. With physical illness, corporeal unity is shattered. The body (or one of its organs) becomes the focus of attention and loses some or all of its capacity for work, play, or human relationships. There may even be loss of an organ or a function. The functional integrity of the whole organism is disrupted by a sick organ, organ system, or metabolic mechanism.

Illness may also assault the psychological integrity of the person in two ways. In one way, emotional illness is a form of dis-integration in which anxieties, obsessions, compulsions, illusions, and other psychopathological disorders assume control of existence. The resulting distortions of the balance and unity of the person interfere with his/her well-functioning as much as the rupture of corporeal unity.

Another form of psychological integrity is the unity of the self in its relationship to the body. When illness afflicts a part of the body, we feel alienated from that part, we stand in some senses away from the offending body, we sometimes reject it and resent it as an enemy. The image we have fashioned of our self-identity in relationship to our bodily integrity is threatened.

We all live with a unique balance we have struck over the years between our hopes and aspirations and the limitations imposed by our physiological, psychological, or physical shortcomings. Serious illness forces a confrontation with the impact of disability, pain, and death on that image. It confronts us with the possibility of a substantially altered self-image or even non-existence. A new image, new points of balance, and a new definition of what constitutes health must be established if we are to become "whole" again.

The Limitations of Autonomy

However fundamental, the patient's moral claim to respect for his or her integrity and autonomy is not absolute. There are several limitations that arise when the patient's moral claim conflicts with the equivalent claims to integrity made by other persons.

One such limitation is the claim of the physician, as a person, to her own autonomy. The patient cannot violate the physician's integrity as a person. If the physician is morally opposed to certain acts, for example, the hysterectomy noted above, she cannot be expected to comply with the patient's autonomy and suppress the integrity of her own person. This will become

an increasingly important matter in public policy as morally debatable procedures such as voluntary and involuntary euthanasia become legalized or, eventually perhaps, benefits of health insurance. Both physician and patient are obliged to respect the integrity of each other's person; neither may impose his/her values on the other. Respectful withdrawal from the relationship may be necessary for the physician or the patient to avoid cooperation in acts which might compromise personal moral integrity. This general principle is difficult to apply in the case of MPD, since the patient's progress through the hurdles of personal, and therefore moral and legal integration, demand the participation of a healer who does not back down or withdraw during difficult moments of the therapy. These moments may well include legal and moral troubles.

Another limitation on a patient's autonomous decision occurs when action might produce a serious, definable, and direct harm to another person. An example here is the patient who is HIV seropositive and refuses to have that fact revealed to his or her spouse or sexual partner. More to the point of this essay, direct harm may come to the parents of the girl whose anger is so intense that it creates "the beast." Taking "the beast" seriously, confronting it, negotiating with it, was an essential and courageous step in the healing process. In this instance the physician cannot withdraw, but he/she has the obligation in justice to tell the person at risk, after first offering the patient the opportunity to reveal the fact himself/herself.

The same limitation applies to the patient who wishes to conceal some health problem which might compromise his/her capacity to fulfill a position of trust – e.g., a pilot, surgeon, or cleric. This was the problem in the first case, when the patient was offered the possibility of informing his family of his struggles, but declined. One could argue that his unwillingness might harm his progeny someday. But this argument would be more remote than one in which direct danger could be proven from a lack of revelation. Note that increasingly, today, the same obligations of disclosure are falling on the health professional with serious disease.³

The autonomous decision of a valid surrogate must also be resisted if there is clear evidence of a conflict of interest, which might lead to the over- or under-treatment of an infant or incompetent adult. The alcoholic parents of the girl in the second case were involved more than peripherally in her treatment plans and care decisions, including the possibility of a hysterectomy. If the therapist believed all of the revelations of her recovered memory, then there would be cause for concern about both their judgments of her best interests and their level of involvement. The physician's primary obligation is the preservation of the integrity of the personhood of his or her patient.

Under circumstances like these, where the daughter is certainly incompetent about some things but perhaps not about others, it is even more important that the physician not withdraw, but rather take any measures available in a democratic society to protect the patient's interests. This protection may mean calling for an ethics consultation, reference to an ethics committee, appointment of a legal guardian, or court intervention to limit the autonomy of the surrogates in emergencies, when the outcome is in doubt and when, in the absence of a specific instruction, the physician must act in the patient's best medical interests. One that springs to mind in the young woman's case, is her repeated self-mutilation attempts. Would the parents call for help if it happened in their home? Or would they themselves be incompetent to do so due to their alcoholism or possible earlier abuse? In general, this added responsibility of the physician should last at least until the patient's wishes were more centered in an integrated personality.

Finally, the patient may on the moral strength of his/her own moral claim to autonomy yield up his/her claim to autonomy. Sometimes the physician has made a sincere effort to involve the competent patient yet the patient does not wish to participate as fully as others might. The patient might then ask that the physician should decide what is "best." Under such conditions, and only these, the physician has a moral mandate to decide for the patient – that is, to act in the patient's place and in the patient's interests. Not to do so is a form of moral abandonment. But the physician must never assume this mandate nor accept it too eagerly or lightly.

The Person of Integrity

These observations and others like them show the complexity of the moral responsibility argument. The law of privacy, the principle of autonomy, and respect for the integrity of persons are necessary but not sufficient fully to preserve the growing integrity of the sick person with MPD in the medical transaction. What is indispensable is the therapist of integrity, the person of moral wholeness, the person of virtue, who can be trusted to respect the nuances and subtleties of the moral claim to autonomy such patients gradually develop over time as their healing progresses. The physician, therefore, must be a person who exhibits the virtue of integrity, a person who not only accepts respect for the autonomy of others as a principle or concept but also can be trusted to interpret its application in the most morally sensitive way.⁴

The ultimate safeguard of the growing integrity of the patient's person is the fidelity of the physician to the trust inherent in the healing relationship. It is the physician who interprets and applies the principle of autonomy.

Much depends upon how the physician presents the facts, which facts he/she selects and emphasizes, how much and how little he/she reveals, how he/she weighs risks and benefits, how he/she respects or exploits the fears and anxieties unique to his/her patient: in sum, how he/she uses his/her "Aeschylean power." Every patient, the most educated and the most independent, is potentially a victim or a beneficiary of that power. This is especially true of the MPD patient, who is quite literally being constructed by the physician based on the elements he or she selects as important in that process. The resultant responsibility is heavy on the physician to be sensitive to the dependent, vulnerable, and frightened state of the patient and not to exploit that state.

Clearly, no contract, law, or abstract ethical principle can eradicate the need for trust, just as trust cannot be eradicated from any other human relationship. The present emphasis on autonomy in bioethics and the law has served to reduce the grosser violations of the integrity of persons. But the physician's character remains the ultimate safeguard of the patient's autonomous wishes.

Paradoxically, to repair the dis-integration produced by any disease, and especially by personality disorders, the integrity of the person must to some degree be violated. The physician lays hands on the patient, peers into every physical and personal orifice, inquires into the details of the patient's social relationships and psychological responses, redefines habitual emotional responses, and deletes some with drugs. This is a licit invasion of integrity to which the patient gives assent. But consent cannot obviate the exposure of integrity to serious risk attendant on medical treatment. This is another source of moral obligation which binds the physician to exercise the right to necessary invasions of integrity with the utmost care and sensitivity.

Autonomy of the patient and of the treating therapist, as now construed, has certain moral and practical limitations; these limitations can be ameliorated by linking autonomy to the principle of respect for the integrity of persons. This move encompasses a more fundamental and richer safeguard for the dignity of both patient and physician than current interpretations of the principle of autonomy. But this richer notion creates moral and legal ambiguity, decisional space as it were, that requires more flexibility in the law than is usually provided. I have suggested that this flexibility, then, is the reason that both patients and physicians dealing with MPD can only be held "minimally" responsible for immoral and illegal actions done by the patient during good-faith efforts over a long period of time to face problems and re-integrate one's personality.

Autonomy, Integrity, Responsibility

Now is a good time to concentrate on the specifics of the idea of normalcy, and relate it to autonomy, integrity, and the sequella of moral and legal responsibility. Autonomy, despite its universal usage in medical ethics, is too often simplistically interpreted, as Faden and Beauchamp have so cogently pointed out.⁵ For example, they make a sharp and valid distinction between the autonomous person and the autonomous action, preferring in their treatment of informed consent to emphasize the autonomous act, rather than the autonomous person. While agreeing with their distinction, I place more emphasis on the autonomous person and on the relationship of that concept to the concept of the integrity of persons which underlies it.

Autonomy, in keeping with its Greek etymology, literally means self-rule. In today's parlance, autonomy has variously been interpreted as a moral and legal claim, a right, duty, concept or principle. There are internal and external constraints which can impede autonomous decisions and actions. Internal constraints include such things as brain damage or dysfunction induced by disordered metabolic states, drugs or injury, or lack of mental competence related to infancy and childhood, mental retardation or psychoses, obsessive-compulsive neuroses, and the worst-case scenario, multiple personalities functioning at odds with one another in a single body. In these instances the physiological substratum requisite to the exercise of the capacity for autonomy is impaired – sometimes reversibly, sometimes not.

Autonomy may be unimpaired internally yet be prevented from operation by external events like coercion, physical and emotional deception, or deprivation of essential information. In these cases the person has the capacity for self-rule but that capacity cannot be realized in an autonomous action, i.e., an action which gives evidence of "autonomous authorization."⁶ An autonomous act is a decision and subsequent act free from internal or external constraints, informed as fully as the situation requires, and consistent with the person's evaluation, at the moment of choice, of the person's own value system. For MPD patients, clearly this level of integration is impossible, as they have internal constraints, lack of full information from each personality of the situation, and no truly coherent value system (although this latter point could be argued, since it is usually upon this value system that eventual integration can be based).

"Autonomy" has become the watchword that symbolizes the moral and legal claim of patients to make their own decisions without constraint or coercion, however beneficent the physician's intentions might be. The socio-political claim to autonomous decision and action was re-entered

by the legal concept of privacy and by the philosophic principle of autonomy. This link is most influential with the courts in America. It is the principle generally used to resolve conflicts about who should make the final decision in accepting or rejecting medical treatments. It is the dominant concept as well in the report of the President's Commission on the withholding and withdrawing life sustaining treatment.⁷

This conjunction of the legal concept of privacy and the moral concept of autonomy has resulted in a widely accepted medical decision-making paradigm: Competent patients have the moral and legal right to make their own decisions, and these decisions take precedence over those of the doctor or the family. When patients are no longer competent (or have never been competent, e.g. infants, the retarded), their rights of decision are transferred to a valid surrogate or to some anticipatory statement by the patient (e.g. a living will, medical directive or durable power of attorney) or in the absence of these to a legally appointed guardian. Some have so absolutized the principle of autonomy and the right of privacy that they would place no limits on its exercise. Others accept varying degrees of limitation on autonomy. The exception I have proposed is that some patients with MPD live a long life, like the electrician in the first case, with moral and legal responsibility more or less intact, even though many "reasons" for impulsive actions, e.g., cross-dressing, experiencing shifts at the full moon, barroom brawls, disgust with the clergy, are long hidden from view. Other patients, like the young woman with "the beast" in her womb, are less able to bear the weight of responsibility for their lives, although in some personalities, she was the epitome of religious ardor.

A strong emphasis on self-determination in bioethics and the law minimizes our ability to recognize the developmental factor in recovery from serious illness, and important gradations in the exercise of and respect for autonomy. In this regard I recall the comedian John Belushi's wife saying after his death of an overdose of cocaine, that John was an adult and had to make his own decisions. What was missed was that John was also very addicted and very sick, sick unto death, and needed help. So there is a temptation to abandon people to their own autonomy.

The emphasis on self-determination also minimizes the physician's obligations of beneficence. Some even see beneficence as antipathetic to autonomy – a false dichotomy as I have argued with Pellegrino.⁸ Autonomy, when viewed as a legal right or even as a moral claim, can severely circumscribe the range of discretionary decisions – those unanticipated choices the clinical situation may force on the physician. Ordinarily the physician would feel free to act in the patient's best interests

as he or she perceives them. Today's environment makes this instinct a legal and moral quagmire.

Finally, the prevailing emphasis on autonomy generates a cult of moral privatism, atomism, and individualism that is insensitive to the fact that humans are members of a moral community. When autonomy is absolutized, each person is a moral atom who asserts his or her rights independently and even against the claims of the social entity to which he/she belongs. Conflicts between the rights of a community and of its individual members raise serious questions of economic and social justice that demand a better balance between autonomy and the common good than now obtains. As I have emphasized throughout my argument, the self constructed in therapy is a mutually developed integration that includes the value systems of the therapist and society, in addition to the moral core of the patient. It is hard to see how a traditional concept of autonomy could work in this relational environment of healing.

Many of the moral shortcomings of the concept and principle of autonomy are ameliorated if we look to the more fundamental concept of integrity of persons of which autonomy is a partial, but not a full, expression. Put another way, by emphasizing the first duty of the therapist to MPD patients as the process of integration, one can respect autonomy as a derivative of this process, and gradually help the patient employ autonomy skills to different situations that used to lead to splitting and dissociation.⁹ We are now ready to analyze the objections to MPD as a disease.

CONTROVERSIES

As I already noted, the diagnosis and treatment of Multiple Personality Disorder has a rocky history and an even rockier future. Some of the major controversies surrounding this disorder are worth examining for a moment, as they impact on the thesis that the disorder is an enormous impediment to moral and therefore legal responsibility for actions. The major controversies have been summarized well in a report by Joan Acocella, a staff writer for *The New Yorker* who asks why so many women have accepted this bizarre but inexact diagnosis and its extreme treatment.¹⁰ My purpose is different in raising and answering the objections prompted by her report, but is indebted to it.

The Nauty/Nice Split

According to the recovered memory movement, one in three American girls were sexually abused as children. If some were repeatedly

abused, they may have suppressed that memory until it emerged later in weird behaviors. Early sexual abuse is virtually an essential component of MPD. Since the abuse is most often aimed at women, this would account for the disproportionate number of women over men who are diagnosed with MPD. In almost every case there seems to be a nauty/nice split between personalities detected – waitress by day and bar-hopping prostitute at night,¹¹ neither knowing what the other is doing until the hard-working single Mom notices that she awakens each morning with an unexplained hangover.¹² Prior to media attention, beginning with the novel and subsequent movie about Eve White¹³ and moving through the 1973 best-seller, *Sybil*, the cases have increased many-fold, and the personalities have become increasingly more zoological and Satanic.

The objection raised by tracing the history of these stories is that the media helped make this disorder a popular part of the woman's movement that targeted the abuse and misuse of women in contemporary society. Acocella summarizes:

Actually, the M.P.D. craze was probably a side effect of the women's movement. While feminism rescued many women from positions of dependency, it left others behind – notably, a large number of working class women.¹⁴

This argument is based on the facts of child abuse and the preponderance of girls who are abused. The movements to liberate women from personal and social repression coincided with the rise in popularity of the diagnosis. Up until that time, all women thought that the abusive relationship “was their lot.” Now, the argument continues, while some of the sisters were being set free, others became more aware of their trapped situation and wondered “how they missed the boat.”¹⁵ Prior to media attention, cases fitting the diagnostic criteria were rare. In a 1944 article two researchers found only 76 cases in the medical literature, but by the decade between 1985 and 1995, almost 40,000 new cases were reported.¹⁶

Almost all the afflicted persons, it is noted, are white, about 30 years old, and suffered abuse as children. As the popularity of the disease spread, people presented with hundreds, even thousands, of personalities. Further, the personalities were no longer confined to human entities; people now presented with cows, chickens, “God,” and “Satan” among their dissociations. They moved from abuse, to sexual abuse, to Satanic cult abuse, and from depressive and suicidal tendencies to repeated self-mutilation, now also considered a diagnostic feature of MPD.¹⁷

To state the objection that might be drawn from these observations squarely, then, MPD seems to be a socially-constructed excuse created by the media around some sensational cases that permits women not to take ownership of their own moral histories and provides a convenient external

object of blame for erroneous conduct, moral and legal. To broaden the objection, one might consider MPD to be an internal form of the ancient scapegoat ritual by which the sins of the community were placed on an animal and then the animal was driven out of the community or sacrificed. It is an internal form because suggestible individuals find the scapegoats within a set of emotional responses they dissociated from their primary personality during early traumatic experiences.

There is merit to this objection. Yet there is also evidence that surviving early childhood trauma requires a dissociative response. In fact, trauma survivors in general attempt many different pathways for coping with horrible realities, some of which are conditions of just such dissociation. I will discuss a good example from Africa, shortly. Suffice to say here that whether or not the media created an increased acknowledgment of the prevalence of this disease, or by contrast, simply created the disease as a construction for the women's movement, does not detract from the dilemmas experienced by patients faced with unexplained conduct that did not seem to proceed from their own considered reflection, or that so obviously violated their conscience. There is therefore an inherent impediment to rational human acts that are formally required for responsibility.

Admittedly our society permits individuals to abjure their responsibilities by blaming their upbringing, or their drug habit, or their parents' neglect, and thereby not taking ownership of their actions. In that environment it is hard to argue that MPD does reduce culpability since it looks like another popular ploy. Yet my observation of these individuals is that they are most acutely aware of the presence of Good and Evil in their life. That is the primary struggle in which they are engaged. To use St. Paul's phrase, they seemed to be on intimate terms with "the Principalities and Powers." Rather than a flight from ownership, I suggest that they are extremely sensitized to their conduct and its implications – so much so, that they "split" over its impact on them. That is why a good case could be made that, despite the splitting of personalities, persons with MPD might very well possess an extremely sensitive moral value system upon which the integration is based.

Cultural Determinism

The second objection concerns cultural elements. It seems odd that MPD is found largely in Western nations, while being almost entirely unknown in other cultures like China. Instead, there, a syndrome exists that, by contrast, is hardly ever found in the West. Every culture has what is called by Anthropologists, an idiom of distress. Mental disorders go in and out of vogue over the centuries. While there is little or no MPD in China and

Asia, there is little or no *koro* in the United States, whereby Asian men are paralyzed by fear that their penis is being retracted into their body. There is widespread *anorexia nervosa* in the West, but in Asia, particularly, there is *koro* instead.¹⁸ This and other considerations suggests a cultural basis for what we call a disease that may, instead, be a social manifestation of distress among a certain population.

The objection could be made therefore that the disease is so highly culturally specific that it bears no real ontological merit, and therefore cannot be taken seriously as an impediment to legal and moral responsibility. Acocella's considered thesis is that "M.P.D. is a memory – a memory of women invoked by men."¹⁹

The answer to this objection rests on a real dilemma. Many diseases are indeed cultural artifacts, but they do rest on a physical or physiological mishap in the human condition. This is then amplified by the values embedded in a culture and designated as a disease. Not many Westerners, for example, consider a woman's clitoris and her sexual pleasure as a "disease." Yet in some African cultures a clitorectomy is required in order to be married, contributing to that culture's perception of marital stability. No dowry is offered for someone left intact, and the young women are considered a burden by their family since they are unmarriageable. By contrast, sickle cell anemia is a plus in some cultures, where it contributes to survival from attacks of malaria.

Thus, the presence of a disease entity in one culture, and its virtual absence in another does not, by that fact alone, constitute a valid objection to the diminished responsibility thesis we are considering. Indeed a good case can be made that there are many individuals throughout the world suffering from depression, suicidal tendencies, dissociation, and borderline personality disorders, and that these run in families. The culture, however, does not address these disorders psychiatrically, and sometimes not even legally. There may be "room" for the medicine man or prophetess or charismatic leader in the culture or its specific history that precludes further analysis. Who is to say what diagnosis we would give to many of the egomaniacal dictators of the modern state, from Hitler, Stalin, Chairman Mao on the one hand to Idi Amin, religious cult leaders, Bosnian zealots, and Hutu and Tutsi slaughterers on the other? In fact, despite their seeming heroic proportions in their time and place, the international community does hold such persons morally responsible. Somaliland executed 32 racial killers. The International Tribunal in the Hague tries racial killers who performed in acts of war in Bosnia.

Perhaps a good contemporary example of a personality disorder running amok is that of Joseph Kony, a young Acholi tribesman from

the north of Uganda. He had a religious background, but upon reaching puberty got caught up in a social movement and eventually became a charismatic, frightening combination of Jesus and the Prophet. He leads very young children (6–16 years old) trained as guerillas on raids against established society. To feed this revolution, he kidnaps young girls from schools, and forces them to become part of his movement. He orders his followers to kill potential defectors. If they do not, they are killed themselves. At other times he is charming and religious, not able to see the disjunctions between his piety and his brutal actions. When children are rescued from him, they require assistance for many years from post-traumatic shock – one young boy returned home, and one day, without changing his affect, got up and hacked a little brother to death, then returned to his place leaning on a tree.

The record of Kony's actions suggest some dissociative disorder. His aunt had similar Messianic tendencies. The "followers" also dissociated in order to survive. One young girl, Susan Akello, after being kidnaped by the rebels, gave herself another name: Susan Alum, so that now, after her escape, she can say that what happened to her, so horribly different than her normal life, did not happen to Susan Akello but to a totally different person.²⁰ Since he is in Africa, this diagnosis of MPD or some other personality disorder is not forthcoming. Instead he is considered a type of prophetic leader who, when challenging traditional tribal chiefs, makes them soil their pants!²¹ Yet his case is illustrative of the point that the lack of diagnosis does not mean that MPD does not exist outside Western countries.

Further it illustrates how culture and history can lead to such brutality. The north of Uganda speaks a different language than the south. In recent history, the northern tribes were recruited by the English for the military, while the southern part of the country was updated and "civilized." Later, under Idi Amin, the northern military were seen by the rest of the country as evil, since they participated in his bloodbaths. Today, under democracy, they feel intensely guilty for the previous actions, and this social guilt has much to do with Kony as with the tribal leaders. Sudan supports Kony because it sees in him a chance to undermine a relatively stable and mostly Christian country to its south.²² Out of a chaotic social and/or familial history, with a very suggestible personality, individuals arise who cope with the trauma of guilt and defeat by dissociating in whole or in part. The question remains, to what extent are they to be held accountable for their actions?

The Relationship Objection

A third objection is posed by a sequella of the first. If in fact the disease of MPD is culturally determined, then it tends to appear only within the relationship with a clinician who “brings it out” into the open. The fact seems to be that some persons are very suggestible, and are able to perform, either under hypnosis or otherwise, in dramatic roles that would both please and appall the care giver. Thus, the objection might be formulated that the physician is a co-equal partner in the disease, and that he or she bears much of any moral and legal responsibility for individuals who do criminal acts in this condition.

This objection is harder to sustain than the first, but is also more difficult to address. I have tried to do so by stressing the co-responsibility of the therapist but also the minimal level of this co-responsibility. More details about this later in the essay.

The “No Necessity Objection”

A fourth objection is that there is no need for the diagnosis, since it cobbles together a variety of recognized problems: substance abuse, child abuse, subjugation of women, depression, suicidal tendencies, and self-mutilation. All individuals are highly suggestible, leading some to “split” hypnotically without the aid of professional hypnosis. Is it not sufficient to let the standard models of mental disorders work without this new disease entity?

A great deal of evidence, or lack thereof, supports the notion that MPD is for the most part a chimera. Over 300 cases of alleged Satanic Abuse were investigated by the FBI and there was found not one shred of evidence. It appears that much of the abuse detected in the recovered memory movement is actually sexual fantasy rather than authentic abuse, and is fed by the probing questions of the therapist. Paul McHugh, director of psychiatry at Johns Hopkins, calls for an end to MPD treatment:

Close the dissociation service and dispense patients to general psychiatric units. Ignore the alters. Stop talking to them, taking notes on them, and discussing them in staff conferences.²³

This approach may be extremely short-sighted, however, if one remains cautious about the “memories” that emerge, and accept the alters as ways of communicating with the broken soul of the patient. Yet to properly answer the basis of all the objections, that disease is social constructed, we must address this issue head on.

Social Construct of Disease in General

One of the more intriguing issues put forward by all reflections on MPD in this issue is the relation of models of disease in health care generally, and especially in psychiatry today, to social values. Not only the diagnosis, but more importantly, the public perception and the indicated responses, are socially constructed. A good example from the past is the story told about Madame Bovary in the Hollywood film version of her life. When she was still very young, she was at a dance. After whirling all night to waltzes and to the intimations of love itself, she felt faint. Her escort announced loudly that the lady was about to faint! The response? They broke all the windows in the hall to let in air! Needless to say this is not the response to fainting we would have today.

Health and disease are building blocks of medical logic, but this logic is not exclusively scientific. In fact, as Rothschuh indicates, disease is a relational structure between sickness, the sick person, the physician, and society. The ill person enters three relations – one to the self, another to the physician, and still another to society and environment – all of which are governed by the need for help. The physician also enters three relations – one of responsibility to the sick person, another to the disease (what is the case? what to do?), and another to society. Society is also involved with individual good for the patient, the common good, and a relationship of aid, prevention, and research on the causes and effects of disease. Rothschuh therefore defines disease as the presence of a subjective, or social need for help in persons whose physical, psychic, *clinical*, or psychophysical balance of boundaries in the organism is disrupted.²⁴ Health, or well-being, on the other hand, is characterized by the presence of order and balance in the organism and no perceived or actual need for help. This analysis recognizes the primary referent of health and disease as conditions of the body.²⁵ It is in this perspective that Thomas' conception of health and disease, derived from years of labor in infectious disease and genetics, focuses on the reactions of a living body to invasion. In Thomas' view, health is a kind of boundary established by a living body. Many diseases are pathologically caused by overreactions of the body to specific agents, e.g., rheumatic fever.²⁶ Using this characterization, the MPD is a person who overreacts to severe physical or psychological stress.

However, social perceptions, and perceptions of the lived body and lived selves, also enter into the notions of health and disease. The tension between organic function and social perception within the concepts of health and disease correct overly broad goals for medicine.²⁷ A disease in the body does not mean that valuational aspects of disease are eliminated. Understanding this tension between organic function and social percep-

tion are keys to dealing with MPD. Recent developments in neuroscience have prompted some psychiatrists to argue that their discipline ought to be abandoned. Those disorders due to organic brain dysfunction, they suggest, ought properly to be turned over to neurosurgery and neurology. All other aspects of coping with life ought to be turned over to counselors and tutors. Although the suggestion is radical, it does highlight an important problem about psychiatry within the context of my reflections on MPD and the problem of evil.

Although psychiatry is usually considered a branch of medicine, it shares with religion a primary focus on the lived self, the symbolic integration as a person. Medicine focuses primarily on perceived needs of the lived body, rather than on the lived self. Thus psychiatry shares with religion the methodology of verbal therapy. Psychiatry is primarily a persuasive art whose therapy consists of understanding, interpretation, and coping. Unlike religion, it does not seek to remove guilt and anxiety; rather, unless these are physically driven and out of proportion to events. Even then psychiatry helps patients to cope. Insofar as psychiatry discovers organic causes of diseases it is medicine.²⁸

Another way of looking at psychiatric attention to the lived self as distinct from medicine is to consider the curative intent of psychiatry. While medicine attends to the living body and the lived body, psychiatry aims at constructing a biography with the patient. The psychiatrist helps the MPD patient form a personal identity from which he or she can construct a possible future. A normal person has sense of a possible future through experience as a past lived self.

Thus, mental illness is a symbolic disorder, as much as it is an organic one. Straus argues that the function of analysis is to help the patient discover his or her own myth (or story).²⁹ The concept of biography is essential to the integration of the MPD patient, and this is why it is so intertwined with cultural issues. One's biography is a history in time, in place, and in culture. For psychiatry, the nature of the dis-ease is an interruption of the lived self. The subject finds an inability to cope precisely because she lacks a sense of being a lived self, a sense of personal symbolic identity and history. In medicine, on the other hand, the patient seeks help *primarily* because organic pain or suffering interrupts a lived body. The lived self is in reasonably good order and can judge that the lived body has not always been this way. A dis-ease in the lived self is a psychiatric symptom, often without pain in the living body or perceived need in the lived body, because the patient no longer has an intact lived self.

Having noted the way in which psychiatry is distinct from medicine, we should also note the ways in which it is, in fact, a branch of medicine.

Although sometimes materially distinct, it shares with medicine the same healing intent and formal methods of working toward that healing in and through the body. Historically part of medicine, and still such through training, psychiatry remains wedded to the body precisely because the body and one's self-image created by corporeal possibilities are intrinsically linked. Despite advances in medicine occasioned by Descartes' rupture of body and soul, psychiatry is that branch of medicine which continually reinforces, indeed presumes, the link between body and mind. Evidence that psychoses have an organic base, the control of manic-depressives and the variety of personality disorders with drugs, and the countless other patterns of mind-body interaction detailed by psychiatry contribute to our understanding of the complex bridge between the body's possibilities, a person's character, the mind, and the environment. In order to reconstruct the lived self, psychiatry, as a branch of medicine, must focus on the body as an object as well.

A RETURN TO THE RESPONSIBILITY THESIS

We already have in place a theory and practice of joint culpability in our legal tradition, and the criminal responsibility of those suffering from MPD has been thoroughly examined in the other papers in this section. In support of my "minimally responsible thesis" I should briefly explain what I mean by "minimally responsible."

The gold standard in psychiatric theory and practice is now well-established. We might charge a negligent psychiatrist treating a homicidal, wife-abusing patient who discharges the patient. The patient subsequently carries out a threat to kill his wife. Most recently in Illinois, a psychiatrist filling in for another on vacation released a wife-abuser back home against the objections of some of the staff. After the release, the patient killed his wife and himself. The physician has been accused of not even reading the chart. He and his lawyer argue that he followed all appropriate medical steps in the discharge.

There are many examples of what we might call a "Tarasoff culpability" in which there is considered a moral and legal co-responsibility on the part of the psychiatrist or institution, for actions committed by disturbed persons when there is reasonable evidence of the treated individual's carrying out a threat, and warnings and other steps to modify this threat when the individual is out from under the control of the psychiatrist or institution are not taken. Like all cases of culpability each must be adjudicated in law on its own merits. Only the general questions and concerns can be addressed philosophically.

Note that in this gold standard, the legal and moral responsibility of the individual patient is still open to defense (by the prosecution that usually argues against any effort to reduce culpability on the basis of mental disorder). Similarly, the treating psychiatrist or other therapist, is considered partially at fault because of an “external” duty to warn. I put “external” in quotes because it sets off a difference from working with MPD, where the joint but minimal culpability would be more “internal” to the whole process of recovery. This difference, if it is an authentic distinction, bears deeper analysis.

In the standard account, the patient’s responsibility for criminal acts, such as killing a girl friend, depends upon the degree to which this compulsion stemmed from overwhelming physical determinates that either diminished or removed free will from the picture. The therapist’s moral and legal responsibility turns on the degree to which he or she could foresee this threat coming to fruition, and the extent to which prudent warnings were given that exceed the normal boundaries of confidentiality in the relationship. Most of the ethical and philosophical controversy about the duty to warn revolved around the demands of prudence in balancing patient confidentiality and the well-being of others who might or might not be his targets.

When it comes to MPD, however, the moral and jurisprudential problems are based more directly in the internal relationship between the patient and the therapist. For their part, the patients are much less coherently moral agents than those driven by compulsion to eliminate an ex-wife. If one could put it this way, there is almost a refreshing directness to such passions than found among MPD patients, who usually are fixated on themselves and on their various and sundry evil challengers. Further the social control over the individual’s environment is lessened, since there are many more individuals acting out in one body. Too, there are greater limits to the psychiatrist’s abilities to predict actions carried out by perhaps as-yet unmet “personalities,” or as a result of the conflicts and interactions among the personalities that are known. The psychiatrist should be viewed as treating a dysfunctional community of quite disparate individuals. As a result of these and like considerations, the joint responsibility for serious infractions of law and morality is diminished compared to other psychiatric disorders. Once again, the degree of this diminishment must be judged in each case.

Indeed, the most fascinating dilemma posed to me by our Psychiatry Chairman, Robert de Vito, M.D., was whether, in conducting a research project aimed at predicting which disordered individuals might have the characteristics of serial killers, participating psychiatrists might have a

duty to warn local authorities or the objects of the individual's compulsive attentions, even though the individual has never committed a criminal act, and is only fantasizing about it. The challenges to responsibility theory in this example, is that the psychiatrist is not, *per se*, a treating psychiatrist, but has only happened upon the suspicion through a research project, the suspicion itself is not yet coherently developed as a full-blown and accepted theory of the gradual disintegration of personality leading to serial killing acts, and the psychiatrist-researcher has no control over the social environment of the suspected individual.

The ultimate problem is, of course, the damage to the individual that would occur from premature incarceration for only fantasizing an action. Imagine what would happen to all of us who suffer the vicissitudes of "downsizing" in academe and who have nurtured the fond hope of early deaths to those who have inflicted this torture on us!

I included this challenge here because it helps delineate the requirements for a general theory of responsibility with respect to MPD, and to those aspects of it in which the psychiatrist might possess co-culpability for illegal and immoral acts. Though not complete, these requirements may be summarized as follows:

1. The individual must be afflicted with an identifiable and socially-accepted disorder. Without this requirement no consensus would exist about impediments to responsible behavior.
2. The disease would require a "natural history," that is, the progressive deterioration of the person could be documented against which any interventions could be judged as either detrimental or salubrious, and the co-responsibility of the psychiatrist could be assessed.
3. For individual co-responsibility, the psychiatrist would have to be treating the patient and possess sufficient knowledge of the individual and his or her place in the progression of the disease for an accurate assumption about predicted acts.
4. The disease necessarily would impel the individual to do certain acts that are illegal or immoral so severely that the individual could not reasonably resist.
5. The treating psychiatrist would have sufficient control over the institutional or social environment minimally to see warnings carry some effect, or maximally, to restrain the individual.
6. Suspicions acted upon would not damage a process of recovery, so that the principle of beneficence would not be violated by that of social utility.³⁰ A person's reputation and confidentiality would still need to be protected.

From these final reflections, one can readily see just how difficult it would be to hold a person with MPD and/or the treating psychiatrist legally and morally responsible for negative acts against others in the community.

CONCLUSION: THE HEADY STUFF

Because human beings are a continuing synthesis of body, spirit, and personal and cultural history, there is a profound connection between medicine and religion. Both sin and illness, for example, are treated conceptually as a diathesis of personal unity. Presumably the body is affected by either. Thus, St. Clement of Alexandria and St. Gregory of Nyssa, Fathers of the Christian Church, basing their thinking on Plato, argue that the director of souls also cures the passions of the body. Such a director of souls is engaged in a *moral pathematologia*, the science of healing disruption. Should we not adopt this conception of therapy too? Is there not a co-responsibility engaged by the therapist, not only for the strictly medical outcomes (progress on certain medications, adjusting dosages, etc.) but also for the moral reconstitution of the individual as a relatively “free agent”?

On the other hand, illness can cause a pathos of a personal nature and also affect the spiritual life.³¹ Because of the personal conditions of a human’s psychophysical reality, Bernard warned that “the physician must not forget in his practice the influence of the moral upon the physical.”³²

The close conjunction of the values of health and virtue can cause confusion, as Kass noted, in the nature of medicine. Does medicine aim at moral virtue? The wide scope of clinical anamnesis requires that the patient explain to the physician how he interprets his life; the physician subjects to interpretation all that is seen and heard. Such mutual interpretation touches very closely on the moral order. I noted how intensely the battle between good and evil is played out in persons with MPD. Sometimes, after a session with such persons, I would wonder long and hard if they were not the modern *loci* of the ancient Biblical battles in desert, such as Jacob’s wrestling with the angel, in which the presence of the Divine is revealed in the simultaneous presence of the awe-ful opposite of evil.

Of all insights into multiple personality, the one that puzzles the most is how different characters, persons even, can inhabit the same body. Even if it is a matter of a highly suggestible person role playing a series of dramatic roles, nonetheless there is much mystery here. For those of us in a Trinitarian religious tradition, this MPD mystery has a parallel. According to our faith, a single God has revealed three distinct persons in one Godhead. Each has a role in human life, but is not a “separate” God.

The best theological explanation of this mystery (such explanations are considered completely inadequate, and indeed may hide more than they explain), worked out through major disputes in early Christian history, is that there are three “persons” in one substance. Contributing an essential component to this theology was the Roman notion of a corporation as a legal person in the law.

I wonder in metaphysical awe (thus the presence of the word “metaphysical” in my title) if MPD might contribute a contemporary understanding of how a single substrate body can include a variety of disparate persons, and how this might affect our deeper understanding of unity and diversity, not only in the Godhead, but also in human culture and multinational affairs.

NOTES

¹ Frederick Crews, *The Memory Wars* (New York: Granta, 1995).

² Edmund D. Pellegrino, “Toward a Reconstruction of Medical Morality: The Primacy of the Act of Profession and the Fact of Illness,” *The Journal of Medicine and Philosophy* March 1979; 4(1): 32–56.

³ For example, Patricia A. Marshall, David C. Thomasma, and Paul J. O’Keefe, “Disclosing HIV Status: Ethics Issues Explored,” *Journal of the American Dental Association* August 1991; 122(9): 11–15.

⁴ Edmund D. Pellegrino and David C. Thomasma, *The Virtues in Medical Practice* (New York: Oxford University Press, 1993), pp. 127–143.

⁵ Ruth R. Faden and Tom L. Beauchamp, *A History and Theory of Informed Consent* (New York: Oxford University Press, 1986); see especially pp. 235–268.

⁶ *Ibid.*: p. 3.

⁷ President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment* (Washington, DC: President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, U.S. General Printing Office, March 1983), pp. 554.

⁸ Pellegrino and Thomasma, *For the Patient’s Good*, *op. cit.*

⁹ For the idea of autonomy as a range of coping skills that arise from the integration of the person, see: Jurrit Bergsma and David C. Thomasma, *Autonomy and Clinical Medicine* (Dordrecht: Kluwer Academic Publishers, 2000).

¹⁰ Joan Acocella, “The Politics of Hysteria,” *The New Yorker* April 6, 1998; 74(7): 64–69.

¹¹ To play on a tidy phrase of the MPD authority Frank Putnam, “librarian by day and streetwalker by night.” Quoted in Acocella: 64–66.

¹² *Ibid.*: 64.

¹³ Corbett Thigpen and Hervey Cleckley, *The Three Faces of Eve* (New York: Mcraw-Hill, 1957).

¹⁴ Acocella: 69.

¹⁵ *Ibid.*

¹⁶ The researchers were W. S. Taylor and Mabel Martin. Acocella: 66.

¹⁷ Acocella reports the averages for MPD patients. Her argument is that MPD is only

a fad disease, cobbled from the real problems faced by these patients: "On the average, people who receive a diagnosis of M.P.D. have already spent seven years in the mental-health system. According to various patient surveys, almost ninety per cent of them are depressed, sixty-one per cent have made serious suicide attempts, and fifty-three percent have a history of substance abuse" (68–69).

¹⁸ Acocella: 72.

¹⁹ Acocella: 79. Here she certainly stretches too far, as the case discussion about a male shows, and she torpedoed her contention since her report is aimed at a female psychiatrist being sued by recovered memory patients who had been diagnosed as multiples.

²⁰ Elizabeth Rubin, "Our Children Are Killing Us," *The New Yorker* March 23, 1988: 61–62.

²¹ Ibid: 56–64.

²² Ibid: 63–64.

²³ As quoted in Acocella: 76, from a 1993 issue of the *Harvard Mental Health Letter*.

²⁴ K.E. Rothschild, "Der Krankheitsbegriff," *Hippokrates* 1972; 43: pp. 3–17.

²⁵ A. Neale, "An Analysis of Health," *The Kennedy Institute Quarterly Report* 1975; 1(1): pp. 1–9.

²⁶ L. Thomas, *The Lives of a Cell* (New York: Viking, 1974).

²⁷ Leon Kass, "Regarding the End of Medicine and Pursuit of Health," *The Public Interest* 1975; 40: 11–42.

²⁸ Ibid.

²⁹ E. Strauss, *The Primary World of Senses: A Vindication of Sensory Experience* (New York: Free Press, 1963), p. 18.

³⁰ Edmund D. Pellegrino and David C. Thomasma, *For the Patient's Good: The Restoration of Beneficence in Health Care* (New York: Oxford University Press, 1988).

³¹ Pedro Lain-Entralgo, *Mind and Body* (London: Harwill, 1955), pp. 132–33.

³² As quoted in *ibid.*, p. xv.

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